

TUSKEGEE UNIVERSITY STUDENT HEALTH SERVICES MEDICAL INFORMATION FORM

Please Read Carefully: This document is the property of Tuskegee University Student Health Center. Immunization information will not be released or sent to other Health Agencies and Educational Institutions. (*Please make a copy for your own records). Incomplete or inaccurate information may delay your clearance, cancel your registration, or cause delays of your medical care.

COMPLETE ALL PAGES/PARTS 1, 2 and 3 as required, and return by June 30th.

Mail or Fax To: Student Health Services

John A. Kenney Hall, Suite 71-235 Tuskegee University

Tuskegee, AL 36088

TEL: 334-727-8641 FAX: 334-724-4437

PART 1:

Name:					Social Security #	[‡] :
Last			Middl		_	
Date of Birth:	Gender: _	M	_FO	ther Er	nail Address:	
Home Address:			_City:		State:	Zip:
Tel: Home	Ce	ll:				
Emergency Contacts	:					
1. Name		Tel:			Relationship_	
2. Name		Tel:			Relationship_	
Semester entering sch	nool (Semester/	/ear): _				
Please check one of th	e following:	_Freshm	an	Transfer _.	Football	_ Vet. Medicine
HEALTH INSURANCE	E (*Skip, If No Co	overage)				
Name of Health Insur	ance:		C	ontract #:	:Grou	p #:
Name of Policy Holde	r:		R	elationshi	ip:	
CONSENT FOR TREA signed by parent or le		egee Univ	ersity Stu	udent Hea	alth Services (*I	f under 18, co-
Student Signs	iture	Par	rent or Le	gal Guard	ian Signature	Date

TUSKEGEE UNIVERSITY STUDENT HEALTH SERVICES

PART 2 -PHYSICAL EXAM

(TO BE COMPLETED BY MEDICAL PROVIDER)

Student's Full Name		Date of Birth									
Date of Physical Exa	m (must be within the last 6 mo	nths):	_Height:W	eight:							
Blood Pressure:	Pulse:										
For Medical Provider, please circle below as indicated:											
	General appearance	Normal	Abnormal								
	HEENT	Normal	Abnormal								
	Neck and thyroid	Normal	Abnormal								
	Heart	Normal	Abnormal								
	Lungs	Normal	Abnormal								
	Abdomen	Normal	Abnormal								
	Genitourinary	Normal	Abnormal								
	Skin	Normal	Abnormal								
	Neurological	Normal	Abnormal								
	Psychological	Normal	Abnormal								
Summary of abnormalities (Attach documents, if indicated):											
List ALL Allergies:											
Is the student receiving medical care for a chronic condition or serious illness?											
Do you feel that there are any mental or emotional issues that we should be aware of?											
Do you have any concerns about the student participating in strenuous physical activity?											
Summary of clinical concerns and recommendations (Attach documents, if indicated):											

PART 3 - IMMUNIZATION RECORD

Fax #: _____

REQUIRED Immunizations: Measles, Mumps and Rubella (MMR). *Two doses of MMR OR evidence of positive titer is required for all students born after 1956. Date of MMR #1: _____ Date of MMR #2: _____ OR Date of Positive Titer: _____ **Highly Recommended Vaccines:** Meningococcal Vaccine – All incoming students; 1 dose on or after age 16 Date of Meningococcal Vaccine: **REOUIRED** PPD (TB Skin Test) within the 12 months: Date given: _____ Date read: _____ Results: If positive, attach Chest x-ray results: Health Care Provider's Signature: Date: Print Health Care Provider's Name: _____ Date: _____ Address: Tel. No: _____